

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2802 STATE FILE NUMBER 63-020050

**FILED JUN 9 1963**

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>55 YEARS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST MARY'S HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>4524 Agnes</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>W.</u> Last <u>Downs</u>			4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-1894</u>	9. AGE (last birthday) <u>68</u>	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>COUNTY GALWAY IRELAND</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>			13a. FATHER'S NAME <u>MICHAEL WALSH</u>		
13b. MOTHER'S MAIDEN NAME <u>SARAH EGAN</u>			14. NAME OF HUSBAND OR WIFE <u>JOHN J. DOWNS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>  </u>		
17. INFORMANT <u>JOHN J. DOWNS - 4524 AGNES</u>			Address <u>  </u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, post.</u> <u>Coronary occlusion</u> DUE TO (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Cardiovascular Disease</u>		
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>  </u>	
20c. TIME OF INJURY. Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. CITY, TOWN, OR LOCATION <u>  </u>	20g. COUNTY <u>  </u>
20h. STATE <u>  </u>			
21. I attended the deceased from <u>5/10/63</u> to <u>5/14/63</u> and last saw her alive on <u>5/14/63</u> Death occurred at <u>10:45</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>H. Underwood, M.D.</u>		22b. ADDRESS <u>5100 E 24th K.C. Mo.</u>	
22c. DATE SIGNED <u>5/14/63</u>		22d. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEMETERY</u>	
22e. LOCATION (City, town, or county) <u>KANSAS CITY, MO</u>		22f. STATE <u>MO</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>5-16-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEMETERY</u>	23d. LOCATION (City, town, or county) <u>KANSAS CITY, MO</u>
23e. STATE <u>MO</u>		23f. DATE RECD. BY LOCAL REG. <u>5-15-63</u>	
23g. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		23h. ADDRESS <u>  </u>	

A. Underwood MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

USE BLACK INK

OR

TYPEWRITER RIBBON

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Dr. H. Q. Underwood  
5100 E. 24 - Be 1-8818  
After 3 P.M.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James E. Hackleman

Licensed Embalmer No. 4523

P. O. Address 4040

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.